 NTIS # PB 88-240122

NATIONAL HOSPITALS
PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT
TAMPA, FLORIDA

December 1 - 5, 1986

Team Members

David Kidder
Gary Gaumer
Judy Williams
Holly Korda
Greg Pope
Brooke Harrow

REPORTS
RA
971
.32
N385
1986
[no.9]

This research was supported by Contract No. 500-85-0015 Work Assignment No. 10: Case Studies of the Impact of the PPS from the Health Care Financing Administration. The views and opinions expressed in this report are the contractors' and no endorsement by HCFA or DHHS is intended or should be inferred.

Abt Associates Inc. 55 Wheeler Street, Cambridge, Massachusetts 02138 TELEPHONE (617) 492-7100
Health Economics Research, Inc. 75 Second Avenue, Suite 100, Needham, Massachusetts 02194 TELEPHONE (617) 444-8910

RA
971.32
.N385
1986
[no.97]

TABLE OF CONTENTS

		PAGE
1.0	**OVERVIEW OF TAMPA, FLORIDA**	1
2.0	**SCOPE OF INTERVIEWS**	3
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	5
	3.1 Financial Conditions and Competitive Behavior	5
	3.1.1 Price Competition	5
	3.1.2 Revenue Diversification.	7
	3.1.3 Cost Competition	7
	3.1.4 Service Diversification	8
	3.2 Administrators' Views on PPS	9
	3.2.1 Hospital-physician Relations	9
	3.2.2 Quality of Care	9
	3.2.3 Program Administration	9
	3.2.4 Payment Components	10
4.0	**EFFECTS OF PPS ON ALTERNATIVE HEALTH PLANS**	11
	4.1 The Structure of the Local Industry	11
	4.2 Competition	11
	4.3 Selective Contracting with Hospitals	13
	4.4 Availability of Hospital Services in HMOs, and the Local Market	14
	4.5 Physician Contracting	15
	4.6 Benefits	16
	4.7 Utilization Control Mechanisms	16
	4.8 Medicare and AHP Competition in Health Care Markets	17
5.0	**MEDICAL PRACTICE PATTERNS**	19
	5.1 Background	19
	5.2 Hospital Responses to PPS	19
	5.3 Outcomes	21
6.0	**THE POST-HOSPITAL HEALTH CARE INDUSTRY**	23
	6.1 Overview	23
	6.2 Hospital Admissions and Discharges	23
	6.3 Hospital Discharge Planning	24
	6.3.1 Organization	24
	6.3.2 Risk Screens	25
	6.3.3 Functions	25
	6.3.4 Problems	26
	6.4 Home Health Agencies	26
	6.4.1 Changes	26
	6.4.2 Problems	27
	6.4.3 Administrative Problems	27
	6.5 Nursing Homes	28

TABLE OF CONTENTS CONTINUED

	PAGE
7.0 PROGRAM OPERATIONS	29
7.1 Peer Review Organization	29
7.1.1 HCFA Contracting	29
7.1.2 The Review Process	29
7.1.3 Denials	30
7.1.4 Changes Since PPS	30
7.1.5 Relations with Providers	31
7.2 Fiscal Intermediary	31
7.2.1 Utilization Review and Medical Review	32
7.2.2 HHA Definitions	32
7.2.3 Denials	33
7.2.4 Earlier Discharges	33
7.2.5 Relations with Providers	34
7.2.6 External Relations	34

PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF TAMPA, FLORIDA

The Tampa Bay area includes two quite different urbanized areas. Tampa, an industrial city of over 680,000, has a large, ethnically diverse work force; over 13 percent of the population are black and there is a large, Spanish-speaking community with a long history in the city. St. Petersburg, separated from Tampa by Tampa Bay and 14 miles of bridge, has emerged as one of the largest retirement communities in the U.S. Its minority population is considerably smaller than Tampa's (7.5 percent black population), and its population is older, with twice Tampa's proportion of persons over 65 years of age.

There are important differences between Tampa and St. Petersburg in the structure of health care resources as well. Inpatient hospital beds are more plentiful in St. Petersburg, with a beds per 1000 population ratio of 7.3, compared to 4.9 in Tampa. Bed availability, a relatively large elderly population, and other factors combine to produce a high rate of Medicare admissions (97.1 per 1000 in St. Petersburg, compared to 48.2 per 1000 in Tampa). However, Medicaid admissions per 1000 are somewhat lower in St. Petersburg (8.2) than in Tampa (12.2). Physician to population ratios are similar, at 2.0 per 1000 in Tampa and 1.6 per 1000 in St. Petersburg.

Most of the hospitals participating in this study in the Tampa area have profited after PPS implementation, despite declining inpatient census. They compete with each other and with other providers (particularly those of aftercare) for patients through charge setting, through the discounts offered to prepaid health plans (HMOs/PPOs), and through service diversification (offering hospital-based home health or skilled nursing care, for example). Competition has also led hospitals to diversify revenue sources, through HMO contracts for example, and to institute programs to reduce costs. Competition has not generated the extensive networking among hospitals that appears to characterize some other markets. PPS is rarely seen by Tampa hospital administrators as a principal determinant of strategy either in markets for medical services or in health care input markets. Factors such as a chronic shortage of RNs have apparently had a larger impact on hospital wage policies than PPS efficiency incentives.

While it is clear that physicians are utilizing Tampa area hospitals differently than they did in the past, the role of PPS incentives in causing the change is not so apparent. Aggressive penetration of managed (rationed) care plans and PRO requirements are very important factors that have been responsible for much of the observed reductions in admissions and lengths of stay. Physicians are not aggressively monitored, pressured, or sanctioned by most hospitals, nor are they aware of any hospital strategy that may pertain to payment or patient mix optimization. In the context of findings from other locations, it does not appear that the more competitive environments for hospital and physician services in greater Tampa has prompted a more aggressive hospital strategy to manage the activities of admitting physicians.

HMOs and other AHPs exert a powerful influence on the behavior of healthcare providers in the Tampa area. In the absence of a long history of provider competition, HMOs have prompted hospitals to bid against each other, in price and in service coverage, to win contracts. Some HMOs have affected aftercare utilization by contracting with home health agencies to provide service to Medicare enrollees but restricting these enrollees' access to these services. HMOs have grown in response to the Tampa Bay area's economic growth and have generally (with one exception) avoided Medicare. In fact, the negative public perception of HMOs in the Tampa area has been shaped by one plan's experience in enrolling Medicare beneficiaries. PPS' effects on HMO behavior has been largely indirect, to the extent that hospitals seeking additional revenue sources have become more willing to contract with HMOs.

The supply of aftercare services in the Tampa Bay area appears more than adequate for current demand, as indicated by low nursing home occupancy and declining census in some home health agencies. However, it may be the case that need for aftercare services, particularly among hospital-discharged Medicare beneficiaries, is not being met. Nursing homes with Medicare-certified beds available do not fill them. New conditions for Medicare reimbursement and increased severity of conditions among the Medicare patient population appear to be factors. Home health agencies are providing high-tech care to this population and feeling pressured by competitors (hospitals establishing their own home health agencies) and regulators (HHAs see the FI squeezing HHAs to meet HCFA's FI performance targets). PPS's perceived impact is in providing a sicker patient for hospital discharge planners to place in home health agencies and nursing homes.

Providers in the Tampa Bay area see the activities of the Professional Foundation for Health Care (PFHC), the area's Peer Review Organization (PRO), as the most concrete, day-to-day demonstration of the new PPS system. Attitudes of individual providers vary: physicians seem more likely to resent review procedures than hospital administrators; some hospitals "get along with" the on-site reviewer more successfully than others. As is the case with the state Medicare fiscal intermediary (FI), PFHC transmits the regulations promulated by the Federal government into its relations with providers through conditions in hospital contracts, the content and frequency of screens on patient documents, and mechanisms for appeal and reviews. Both the PRO and the FI profess a commitment to provider education before changes in payment rates, during the review process and, if necessary, during proceedings leading up to sanctions.

2.0 SCOPE OF INTERVIEWS

There are forty six hospitals in the Tampa-St. Petersburg-Clearwater, Florida, metropolitan area. Thirty five are non-Federal, short-term, acute-care facilities, of which nine are in Tampa and nine, in St. Petersburg. Eight hospitals participated in the area case study including three in St. Petersburg and five within and on the outskirts of Tampa. They range from large, teaching institutions to small, community-oriented facilities. Both proprietary and voluntary hospitals were visited, the latter a mix of church-affiliated and unaffiliated hospitals. All hospitals are urban by HCFA's definition. However, one serves a largely rural area.

Fifty two people were interviewed during the five-day site visit. Table 1 summarizes the interviews by topic area and the positions of the respondents. Twelve interviews focused on the financial positions of the hospitals, their competitive environment, and related topics. Thirteen were concerned with the utilization of resources and patient management in the hospitals. Fifteen were conducted with those involved in the post-hospital health care industry and six were with representatives of the PRO and fiscal intermediary. The directors of four health maintenance organizations were interviewed about competition in their markets and the impact of PPS on them.

To gain insights into the competitive environment of the Tampa-St. Petersburg area, six chief executive or operations officers were interviewed about their strategies and the relative positions of their hospitals under PPS and in the area's health care market. Information relating to price competition and financial standing was obtained in interviews with six chief financial officers or hospital controllers.

In the area of utilization of hospital resources and patient management, the site team spoke with five utilization reviewers, two chiefs of staff, two medical directors, and six physicians. For the aftercare industry, team members interviewed six hospital discharge planners, administrators of four nursing homes and four home health agencies and the director of the Area Agency on Aging. Interviews concerning program operations were conducted with one representative of the PRO and five of the fiscal intermediary. Four directors of health maintenance organizations were interviewed concerning the organization of that industry in the Tampa area.

TABLE 1

TAMPA, FLORIDA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations	HMOs
CEOs/COOs	6				
CFOs	6				
U/R Coordinators		5			
Chiefs of Staff		2			
Medical Directors		2			
Other physicians		6			
Discharge Planners			6		
PRO Administrators				1	
Fiscal Intermediary Representatives				5	
HMO Directors					4
Nursing Home Administrators			4		
Home Health Agency Administrators			4		
Director of Area Agency on Aging			1		
Total Number of Interviews	12	15	15	6	4

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

Hospitals in the Tampa Bay area compete with each other and with other health care providers in both product and input markets. On the product side, hospitals compete through pricing policies, through attempts to diversify or strengthen offerings of particular services, through measures to become more efficient and through policies designed to broaden the revenue base. On the input side, Tampa area hospitals face what is perceived to be a chronic shortage of trained registered nurses; this is promoting an increase in the competitive wages in nursing markets. In certain other occupational categories (pharmacists, for example), there is also some market pressure on wages.

3.1 Financial Conditions and Competitive Behavior

Most hospitals in the Tampa Bay area have earned higher net incomes since PPS was implemented. At the same time, none of the administrators who were interviewed attribute these gains to PPS. Many argue that their hospitals lost money on Medicare patients after the advent of PPS. The source of higher profits, in their view, is to be found in adjustments targeted toward non-Medicare patients (cost shifting to charge payers, in the case of one hospital) or to general cost saving improvements. Every hospital but one reports a decline in patient census, and an accompanying decline in occupancy.* However, length of stay experiences differ among institutions. Most report declines, in both total and Medicare lengths of stay. A few note that Medicare lengths of stay have, within the last year, increased slightly. Administrators speculate that increases in case complexity may be responsible for this latter trend, but have no data to support this explanation. The data available on casemix changes are inconclusive on this point; hospitals reporting recent increases in Medicare lengths of stay report increased values of their CMIs, but hospitals reporting decreases in lengths of stay also report CMI increases.

3.1.1 Price Competition

Most administrators agree that competition in the Tampa Bay area is fierce, and that hospitals use charge structures in a competitive way. Hospitals in Florida are limited in this regard, however. Florida's Hospital Cost Containment Board (HCCB) applies screens to both net and gross revenues per admission. Blue Cross pays reasonable charges, and

---

*The one exception to the rule of declining admissions is a proprietary hospital. The reasons for its growth are not entirely clear. The hospital promotes its service aggressively, and uses other strategies to compete. Its emphasis on the amenities available in a proprietary hospital may have drawn new business from higher income patients. The "quality of life" in both proprietaries, in terms of amenities for patients and staff, appear quite high; this may be due, in part, to the considerable underutilization of both facilities (occupancies averaging from 30 to 50 percent).

subjects each participating hospital to a thorough financial review. Administrators appear to have a good sense of how both their charges and costs compare to market averages, but profess to be unaware of how specific competitors use pricing to compete. As one administrator notes, hospitals "don't talk about prices (to each other) any more."

None of the administrators see routine care as price sensitive. Room rates have generally risen in Tampa area hospitals at about or slightly above the medical component of the Consumer Price Index (5 to 6 percent annually). However, there is considerable agreement that certain services are price sensitive, and that volume increases might be obtained by reducing charges. Emergency room care and ambulatory surgery are viewed in this light by several administrators. Some mention labs and radiology, but the competition for the latter is unclear. One CFO feels that radiology is "price inelastic", and notes that charges for x-rays have been increased substantially at his hospital along with other ancillary charges. Another CFO holds a contrary view, reporting that his hospital has cut radiology charges. The effect of this move on the hospital's x-ray volume is difficult to measure, because radiologists have also set up a competing freestanding radiology clinic to compete with the hospital.

Hospital charges are a signal to the market but, for most payers, they are not the prices actually paid for services. Most hospitals in the Tampa Bay area have four or five contracts with HMOs and/or PPOs, with a variety of discounts applied, depending on the scope of benefits provided, volume incentives and the like. Discounts on charges range from 5 to 30 percent. Trends in Medicare discounts vary. Some hospitals see their cost-to-charge ratios increasing, when "holding the line" on charges is used as a primary strategy. Others see a decrease. Only one hospital argues that it uses charge setting to offset losses, shifting the burden of Medicare losses and of indigent care to charge-paying customers. This church-affiliated hospital chooses to pursue a "preferential option" for the poor espoused by the church, and uses its pricing policies to support this goal.

Price competition extends to input markets as well. Hospital administrators in the Tampa Bay area report a severe nursing shortage. They attribute the shortage in part to PPS and other cost containment measures, arguing that as PRO pre-admission reviews screen out more and more of the less severe cases, hospitals admit a more severely-ill casemix while at the same time, faced with pressures to cut costs, hospitals freeze staff levels or lay off less skilled nursing staff (LPNs and aides). The remaining nursing staff must work harder to care for the sicker patients, adding to their duties many of the unpleasant tasks formerly performed by aides. Nurses in the Tampa Bay area also face chronic seasonal swings in employment, with many facing layoffs or forced vacations during summer months when area retirees return to the North. Many hospitals have reacted to this shortage by increasing nursing wages faster than wages of other employees. One administrator notes that high net revenues earned since implementation of PPS have been used to fund such wage increases.

3.1.2 Revenue Diversification.

Most hospitals in the Tampa Bay area have tried to protect their revenue bases by contracting with HMOs and PPOs. Few administrators point to either revenue or volume increases associated with these contracts. Most feel that capitated payment contracts help a hospital "hold its own" against other hospitals and providers with similar contracts. HMO competition in the Tampa Bay area also plays on hospital rivalry. An administrator of one proprietary hospital notes that HMOs force hospitals to compete with each other in prices and services.

Two hospitals with long histories of service to indigent patients are working hard to expand their shares of private pay patients. For one, this means aggressively seeking out HMOs. For the other, upgrading amenities and promoting the hospital's image in the community are the preferred approach. The latter policy owes something to the philosophy of this hospital's medical staff, which has viewed HMOs with some skepticism fueled, in part, by unpleasant experiences of many area providers with certain local HMOs.

Many of the voluntary hospitals in this group are in the process of discussing financial reorganization under a parent holding company, to permit expansion into for-profit activities. A few have already reorganized. One administrator, in reporting that a reorganization is in the planning stage, stresses that his board is not anxious to plunge into profit-making activity without careful consideration of how any potential venture relates to the provision of health care.

3.1.3 Cost Competition

Hospitals may compete by trying to be more efficient; however, the traditional view has been that cost and price competition cannot be important as long as major payers pay on the basis of cost. Under prospective rates, hospitals have incentives to cut costs in order to earn positive net revenues.

PPS's clearest cost-cutting incentives are in patient management. The shorter the stay, the more the hospital benefits financially. All of the hospitals in the case study try to make physicians aware of the linkage between stays and net revenues for Medicare patients. Methods for accomplishing this are generally not harsh. In some hospitals, a DRG-specific update, including days spent relative to the "standard" length of stay for the DRG, is added to the chart. In others, pressures are informal: general discussions at staff meetings, conversations between physician advisers and medical staff.

Most administrators have opted to keep peace with their medical staff rather than risk a confrontation over practice patterns. One administrator, from a church-affiliated hospital, states that the hospital stands by its staff completely, particularly with respect to physician control over criteria for admission. This position has brought the hospital into constant conflict with the PRO over the use of pre-admission screening for Medicare and Medicaid patients.

Many hospitals in the Tampa Bay area have instituted cost-saving programs. Few, however, attribute these efforts entirely to the implementation of PPS. One hospital instituted an acuity system for scheduling nursing staff in 1980; this was perceived as a response to the nursing shortage in the area. The same hospital has invested in a long list of technical improvements including cost-saving systems for heating and air conditioning, water supply, etc. The impetus for these changes is seen by the chief executive officer to be the Federal wage-price freeze of the early 1970s. Another hospital implemented a series of sweeping changes (including massive reductions in staff, implementation of a cost accounting system and changes in wage policies) that coincided with an administrative reorganization in the early 1980s. The general impression conveyed in this site visit is that each hospital that has instituted cost-cutting policies has responded to forces that are of particular importance to it, and that PPS, in all cases, is a secondary but not unimportant force. Isolating what independent contribution PPS made to the process, however, is virtually impossible for respondent CEOs and CFOs.

3.1.4 Service Diversification

Under cost reimbursement, hospitals found it expedient to compete with one another by adding services and amenities. Under PPS, there is no evidence that hospitals in the Tampa Bay area have rejected this non-price competition. However, accumulating pressures toward increased efficiency have led to policies that will inevitably constrain the expansion of services in some hospitals; these policies include equipment budget freezes and sharing of services by some hospitals.

Some Tampa Bay area hospitals have expanded primary and aftercare services. One hospital has increased its holdings of clinics from two to five in the last two years, with the goal of increasing its overall market share. Another opened a home health agency, after finding it difficult to place its Medicare patients in other HHAs. The same hospital has plans to purchase a nursing home. However, this decision is based less on financial considerations and more on concerns of the present owners that the facility remain open and provide good quality care. One large teaching hospital has strengthened its offerings of sophisticated medical and surgical services in the last two or three years, adding a renal transplant center and a burn care center. The rule in service expansion among most Tampa Bay area hospital administrators appears to be caution, however. For example, one comments that his hospital will not acquire a lithotripter in the near future, as a nearby for-profit group is already providing this service.

Most hospitals have developed and implemented guest relations policies, and some have made major commitments to improving physical amenities. Once again, however, the timing and content of these programs often relates more to the specific history of the institution than to PPS. One hospital, with a history of serving large numbers of indigent patients, has embarked on a major capital improvement program designed, in part, to improve the "image" of the facility to charge-paying

patients. It has also implemented a guest relations program, moving from general training sessions for all staff to targeted sessions designed to increase the sensitivity of staff most exposed to the public (telephone operators, ER staff, admitting clerks).

3.2 Administrators' Views on PPS

None of the administrators argue that the current prospective payment system should be scrapped. However, several have comments on the general and specific features of the program, and on how the program is presently administered.

3.2.1 Hospital-physician Relations

Several comment that PPS pressures hospitals to change, but leaves physicians virtually untouched. Some feel the same type of prospective payment system should be applied to physicians; it is a "slap in the face to hospitals by not doing that." In this view, PPS increases the level of conflict between administrators and the medical staff. On the other hand, as one administrator notes, it can also increase the level of communication.

3.2.2 Quality of Care

Many administrators see a potential for PPS to lead to lower quality care. Most see this as a future problem, at worst. One predicts an inevitable move toward a two-tiered system of health care, with Medicare recipients getting less than non-Medicare patients with the same condition. To emphasize his point, this administrator says that he would open a separate ward for Medicare patients and provide a lower intensity of care, if he could, because current reimbursements do not pay for the quality of care his hospital has customarily provided. Another comments that the profit margins his hospital has earned under PPS are needed to maintain an acceptable quality of care.

3.2.3 Program Administration

Most administrators feel the fiscal intermediary in Florida performs well. Their principal concern is delay in payments, which they feel will be particularly burdensome when Periodic Interim Payments (PIP) are discontinued this year. This disappearance of PIP is likely to affect the cash flow of hospitals with a large number of disputed claims.

Hospital administrators in the Tampa Bay area have mixed feelings regarding the PRO. Some have been able to avoid 100 percent review, and have developed good rapport with individual PRO staff assigned to their hospitals. They tend to view the PRO as a potential problem, however, whatever their current situation. Their comments are less specific than those of physicians, who tend to have well-defined concerns about how PROs use protocols and lists of conditions to determine eligibility for admission.

3.2.4 Payment Components

The update factor and outlier payments receive the most negative comments, although a few administrators comment on other specific payment components. Outlier payments are considered "terrible," in the words of one. The update factor is calculated "whimsically," according to another.

More generally, changes in the methodology are perceived to be made too often; there is a need for stability and predictability. One administrator comments that the inflation adjustment should be more sensitive to variations among regions in labor and supply costs. The capital payment methodology receives little comment beyond the suggestion that payments should continue to be "hospital-specific." Payment for medical education is an issue for one administrator, who notes that under the new system it is less feasible to cross-subsidize the university component of medical education.

4.0 EFFECTS OF PPS ON ALTERNATIVE HEALTH PLANS

4.1 The Structure of the Local Industry

The Tampa/St. Petersburg health care market sponsors a growing number of alternative health plans (AHPs). Four HMOs were based in the area as of December 1985. Current estimates have identified as many as 15 to 20 plans (including 2 Cuban HMOs operated by private social clubs), most of which are less than 1 year old. The market is characterized by the presence of several national plans, sponsored by large insurance companies and proprietary hospital chains, and fledgling IPAs and physician groups established to compete with the large plans. According to one respondent, virtually every major national plan, with the exception of Maxicare, has some presence in the area.

Private commercial insurors exert a strong presence in the local health care market, especially in recent years, as Tampa's economy continues to recover and gain strength. Even Blue Cross/Blue Shield, which holds 10 percent of the Florida market, has recently entered the HMO market. Proprietary facilities -- hospitals, walk-in clinics, and ambulatory surgery centers -- that have traditionally been a mainstay to Tampa's health care delivery environment, also play a significant role in alternative health plan networks.

Interviews were conducted at four HMOs among the growing number of plans in the Tampa/St. Petersburg area. Two of the area's largest plans, each with enrollments greater than 40,000 members, were included in the sample. Only one HMO enrolls Medicare beneficiaries, although the plan's contract was slated to be discontinued January 1, 1987. A second plan offers supplementary benefits only. Medicare beneficiaries are also served under a risk contract by a Miami-based plan, which did not participate in this site visit to the Tampa/St. Petersburg area. This plan is Florida's largest HMO with over 150,000 Medicare enrollees. Seniors account for approximately 75 percent of plan membership, giving this HMO, which serves the south Florida region, the largest Medicare membership in the nation.

Recent media attention directed to the quality and accessibility of services in HMOs has created a defensive posture among plans in Tampa/St. Petersburg. South Florida HMOs have been the center of both national and local attention following exposure of one plan's experiences with Medicare enrollment. Allegedly, members have been enrolled under false pretenses, services are inaccessible and provider payment is difficult to recover. Local plans feel that this adverse publicity has affected the potential growth of all HMOs in the area, and "may put the skids on capitation in Florida."

4.2 Competition

Competition in Tampa's market for alternative health plans has increased recently, on the heels of increased competition in the hospital sector and a resurgence of growth in the local economy. Decreasing occupancy rates are the result of both the PPS and private sector

interest in cost containment, as national employers expand their presence in the area, and these declines have especially fueled local interest in prepaid health plans. Projections that growth will continue further contribute to AHP interest in the Tampa market, and in the enrollment of employer group members.

Features specific to the recent growth of the Tampa/St. Petersburg area have played a significant role in shaping the types of competition among providers and payers of health services. Tampa's health care system experienced continuous growth from 1976 through 1982. According to many respondents, the supply of hospital beds exceeds local demand. Shortened lengths of stay, attributed in part to the PPS, contribute to average occupancy rates of 50 percent for the Bay area. Many facilities are reportedly operating, profitably, with as many as one-half or more of their beds empty. The local health council reports that on any given day there are 1900 empty hospital beds in Pinellas County, where Medicare accounts for 33% of the patient population and 1,000 empty beds in neighboring Hillsborough County, where 11 percent of patients, comparable to the national average, are Medicare beneficiaries.

Seasonal variations in health service utilization and low provider payments for the large Medicare population affect the availability of services and delivery arrangements in the fee-for-service sector, as well as the possibilities for managed health care for area elders. The migration of "snowbirds" to the St. Petersburg area boosts hospital occupancy rates to between 80 and 90 percent in winter months, and to as high as 102 percent during the month of February. Medicare covers a high percentage of these winter residents. Fee schedules for medical and surgical procedures are considerably lower in Pinellas and Hillsborough than in surrounding counties. Physician to population ratios also appear high in the area, with one physician per 420 people. These features of the health care delivery environment have encouraged HMO competition for employer groups, but tend to discourage plans from risk contracting with Medicare.

During the past 5 years, the Tampa/St. Petersburg health care market has been host to numerous corporate buyouts by large national investor corporations. Small proprietary hospitals were the first to be acquired. Tampa's hospital market, now, was been likened by one interviewee to "the boom and bust of the real estate market in Houston, Texas." Two of the area's large proprietary chains reportedly "want out," having entered the market to obtain investment tax credits. The price of a hospital bed is estimated to have fluctuated from $80,000 per bed to $250,000 per bed, and then dropped to $50,000 per bed, all within the past 5 or 6 years.

The continued strength of the sunbelt boom promises to add an additional 300,000 residents to the area by 1990. Anticipating this growth, large insurors and hospital chains have focused on HMO acquisition and buyout opportunities as a means of market entry and growth. Small IPAs, developed by physician groups as alternatives to national managed care systems and solo practice, have been particularly vulnerable to competition posed by these large firms. Most small groups and new plans lack sufficient access to capital, necessary for start-up and development, to compete successfully.

These competitive pressures have been responsible for the very formation and sponsorship of one of the IPA plans in our sample by the local medical association. This HMO was established "to prove that fee-for-service physicians could be competitive in price" with other HMO and group service delivery plans. Seven hundred member physicians, representing licensed MDs and DOs in four counties, have each contributed membership fees to a management company for administrative expertise.

Most participating physicians who have elected to practice through the plan (described as Tampa's "Yuppie Health Plan") "want to maintain their practice styles - they want to continue to be their own boss." Increasing competition from other plans is making this more difficult, and physicians will reportedly be advised to reduce fees as much as 25 percent -- or face significant restructuring or acquisition. Because the plan is, in fact, directed by the physicians, management can only suggest, not impose, alternatives for remaining competitive.

The threats that changing health care delivery styles pose for this HMO are typical of the pressures facing other Tampa area health plans as large chains and indemnity insurors enter the market. One of the area's new HMOs, sponsored as part of a multiple option by one of the nation's large indemnity insurors, reports that in increasingly competitive markets, plan reserves and access to large pools of capital are likely to "make it or break it" for plans. With parent company assets in excess of $88 billion, this new IPA is part of a larger expansion to 5 areas of Florida, involving contracts with 4,000 physicians and 35 hospitals statewide. This plan, like its other affiliates, has been formed both by acquiring local IPAs and by assembling new groups through networking arrangements.

Acquisition and buyout are viewed by some HMOs as opportunities for financial gain in these conditions of new and growing competition. Tampa's largest HMO developed as a physician-sponsored IPA. It is also in the process of restructuring, having been recently purchased by a conglomerate formed by a large, national insurance company and a proprietary hospital chain. This acquisition apparently provides significant returns to the plan's physician owners. So lucrative is this type of acquisition that many small physician groups in Tampa are beginning to eye their own formation and acquisition as a potential competitive strategy. Nevertheless, however eager some local providers may be to cash in on market dynamics, critics of this approach caution that the full effects of corporate ownership and control on physician autonomy and practice style are still two to three years away.

4.3 Selective Contracting with Hospitals

Executives at all of the HMOs mention that most hospitals in the area are still somewhat new to and somewhat skeptical of HMOs, and vary in their willingness to negotiate with plans. Proprietary hospitals are reported to be more willing to enter into contracting arrangements than local, non-profit facilities. The proprietaries are also known to accept the concept of plan-managed care more readily than their competitors. Most plans prefer to contract on a per diem basis with hospitals.

However, discounted charges are still negotiated with a significant number of area hospitals. Volume discounts are also fast becoming a standard feature of many HMO contracts with hospitals.

Selective contracting with hospitals to achieve cost efficiency for the HMO is an established practice at the two insurance-sponsored plans. The two other HMOs, both physician-sponsored IPAs, contract with a broader range of hospitals, generally those facilities with which participating physicians have privileges. Most respondents indicate that, with a few exceptions, consumer preferences for services by particular hospitals do not play a major role in plan negotiations. The prevailing view among plans is that consumers are not sufficiently aware of differences among hospitals in the quality or availability of services. Insuror-sponsored plans appear to be particularly conscious of hospital costs in selecting participating hospitals. One plan, in particular, focused on hospital negotiations to achieve comparative advantage over other AHPs and fee-for-service options.

Additional criteria by which hospitals are selected for negotiation include:

1) the variety of services they provide;
2) their cooperativeness with the HMO;
3) the hospital's image in the community; and
4) which physicians are on staff.

An executive at one plan, who negotiates the plan's contracts with area hospitals, reports that, with declining length of stay and numerous hospitals to consider for potential negotiation, the HMO can exert considerable influence in obtaining discounted rates for the plan. Relatively open admitting privileges at local hospitals often facilitate competitive negotiation, because the plan can shift its physician affiliates from one hospital to another with ease. These pressures are slowly moving hospitals to accept contracts with capitated plans. "One of the larger hospitals that wouldn't talk two years ago has now come around," seeking a contract with the plan.

4.4 Availability of Hospital Services in HMOs, and the Local Market

Despite factors such as low occupancy, which frequently spur market segmentation or specialization of services under conditions of mature market competition, hospitals in the Tampa area, which have more recently initiated competitive approaches, have not specialized within their market. Because most hospitals do offer full service availability, HMOs are not usually approached by hospitals seeking to market specific services and the plans do not selectively contract across hospitals for particular service arrangements. A notable exception is cardiac surgery, which one plan has found more cost effective to refer to a center in Houston, Texas. This particular arrangement is also known to be used by plans in other parts of the country, extending competition beyond the confines of local hospital markets.

One executive suggests that the newness of HMOs to the Tampa market, their relatively low market share (5 to 10 percent until recently) and the recent turn to competition among local hospitals may explain Tampa's rather conservative health care provider response. Two additional factors are cited as important to hospital service availability and their arrangements with HMOs: a general skepticism about capitation plans, by providers as well as consumers, resulting from adverse media attention about HMOs in South Florida; and the proliferation of non-hospital service alternatives, such as ambulatory surgery centers, clinics, and office-based services in the community. IPAs, in particular, have tended to use these alternatives, often as a substitute for more traditional hospital-based services.

Access to nursing home placements for HMO members tends to be a problem for local plans. Although senior membership is a small proportion of HMO enrollment, this problem only adds to the potential difficulties plans face when serving Medicare populations. Home health care, provided by local organizations outside of the plan, is more readily available for all enrollees (compared to nursing home beds), as it is for patients outside of managed care networks.

4.5 Physician Contracting

Each of the four plans participating in the site visit negotiate different types of contracts with physicians, ranging from salaried positions in the staff model HMO to full or partial capitation arrangements and rates by fee-for-service schedule in IPA and group models. One of the larger plans negotiates two types of capitation payments with physicians and physician groups. Plan physicians, most of whom hold exclusive contracts with the IPA, may contract for either primary care capitation or more commonly, for full capitation payment, without a hold back reserve account.* Full capitation arrangements have presumably been preferred with clinics and multi-specialty groups under contract to this HMO. Bonus payments are offered if hospital utilization is down.

One of this plan's competitors, operating like a modified PPO, uses a fee schedule and 20 percent withholding. Another local IPA uses a fee schedule for physicians, subject to a fee maximum set at 90 percent of usual and customary charges and collective withholding for participating physicians. Further reductions are being considered, spurred by competitive pressures from other health plans.

The terms and incentives of provider risk arrangements in HMOs are the subject of growing concern. Physician referrals to hospitals or specialists are perceived to be closely associated with the degree of risk providers are required to assume under capitation contracting arrangements. Most Tampa plan administrators are sensitive to this

---

*A hold back reserve account is a common risk-sharing arrangement in which a portion of a physician's payment is retained by the plan as an incentive for controlling utilization and insuring against excessive costs of care.

dynamic, and the potential that capitation incentives may create for underutilization of services. One of the area's large Medicare HMOs received heavy criticism for its subcontractor arrangements, which place physicians at full risk for total patient care. Some claim that physician contractors to this HMO have restricted member access to needed services.

4.6 Benefits

Offering health care benefits as part of a multiple benefit offering is described as a significant element of corporate strategy by Tampa's two largest HMOs, and by new plans sponsored solely, or as joint ventures with insurance companies. Following this approach, most of Tampa's HMOs currently offer or are planning to offer at least PPO and/or indemnity plans in addition to the HMO benefit. Insurance-based plans, in particular, are likely to offer such triple benefit options, often including the same providers under different contracting arrangements.

Developed HMOs are also likely to tailor their benefit packages as part of plan marketing to employer groups. One local plan has gone so far as to provide 35 different prevention and wellness programs and a health assessment program in-house or on-site at the workplace. Services, directed to "the people who like to jog," include drug and alcohol programs and focus on "helping people to get well - and stay well." In keeping with the plan's corporate focus, the HMO plans to discontinue its Medicare business, focusing on benefits for the groups it feels it can best serve. "The elderly are a different population, with very different health needs. They need maintenance care - and don't get 'well' with the problems of age."

Another strategy that is growing among insurance-sponsored plans in Tampa is to provide "one-stop insurance" for employer groups and employee members. A broad range of coverage, from auto to life to health care, may be available under such programs. Existing contracts with major employers for non-health benefits facilitates expansion into health care benefit products and, alternatively, permits health plans to expand their benefit offerings to include other insurance products. In most cases, these packages are planned only for areas served by major employer groups.

4.7 Utilization Control Mechanisms

Utilization review programs, which vary in scope and stringency, have been established at each of the four HMOs. At all plans, the primary utilization review activities focus on cost efficient practices and use of services, and are performed by medical professionals.

At one large IPA, charges and claims are approved by nurse coordinators. Physicians in physician groups, who are provided with strong financial incentives to manage patient care through partial or fully capitated risk contracts, usually self-monitor, but must fulfill a nine month residency requirement for plan membership. At another plan, sponsored by a large insurance company, an in-house RN performs preadmission certification and retrospective review, along with some concurrent review. Patient care management, or "gate keeping"

activities, are performed by a plan physician. Additional screens are provided for cost and referral. One plan also offers bonuses to physicians when hospital utilization is down, as part of its capitation arrangement.

Sanctions on physicians for aberrant practices are rarely imposed, but retrospective physician profiling at one HMO did lead to the dismissal of a participating physician. At this plan, patients are allowed open access to providers in PPO-like fashion, and are not subject to gate keeping restrictions. Patient profiles are prepared per episode of care, examined by the plan, and reviewed by a physician case management coordinator.

4.8 Medicare and AHP Competition in Health Care Markets

Most industry representatives attribute few changes in their plan structure or contracting arrangements to PPS. HMO representatives describe hospitals in the area as "sluggish" in adapting to competitive pressures. Competitive activities pursued by hospitals as well as by plans appear to be directed to a great extent by corporate restructuring and acquisitions initiated by proprietary hospital chains, major insurance companies, and the existence of ambulatory alternatives to inpatient care made possible by technological advances and a well-insured patient base, not to regulatory changes.

While evidence of PPS effects on HMO activity is not corroborated by plan representatives, concern about Medicare capitation contracts and about the effects of recent television and newspaper reporting of one particularly noncompliant plan is expressed by every respondent, at each of the plans approached in the Tampa area. Several criticize the media for their "blood thirsty" and "vindictive" attacks on HMOs, which included a week long expose of the industry, with a particular focus on allegedly unscrupulous practices for marketing to and enrolling Medicare members, inadequate service delivery, and provider payment mechanisms.

Respondents at all of the HMOs are skeptical that enrollment of Medicare beneficiaries could be successful in the Tampa/St. Petersburg area. Only one plan of the four holds a contract with the Medicare program, on a cost basis, and this is scheduled for termination by the HMO on January 1, 1987. At its peak, the plan served more than 6,000 beneficiaries. Enrollment in December, 1986, included 2,500 Medicare members. High hospitalization rates for the group, which includes 41 dialysis patients, have placed severe financial pressure on the plan. This experience is a major factor in the decision to discontinue participation with Medicare. Until two years ago, this HMO had offered a high option supplement plan to beneficiaries, including a full hospitalization benefit, which has subsequently been trimmed to maintain premiums at a competitive level. For Medicare enrollees, the plan averages 2,800 hospital days per thousand, above the expected average of 2,000 hospital days. Now the plan will focus on more profitable employer groups: "the groups we serve best." Respondents describe the plan as the 'Sears' of HMOs, a 'middle class plan' known for its consistency of service and the convenience of its locations throughout the area.

During the transition out of Medicare, contracting staff at the HMO have informed beneficiaries of supplement programs available at other HMOs and have established a hotline to assist with problems that may arise. The greatest difficulties mentioned involve beneficiaries' lack of understanding of the fee-for-service system, their health benefit coverage under Medicare and other health insurance plans and how to obtain services outside the HMO network. "For the first time, many beneficiaries must deal with confusing issues of health insurance. In these competitive times, it's a challenge for anyone -- but especially for the over-65 group." Some beneficiaries, notified of their terminating coverage, have elected to enroll in a Medicare supplement program available since September, 1985, through Tampa's largest IPA network. (The supplement covers durable medical equipment, but does not include prescription drugs or vision care services offered by many HMOs to attract beneficiaries who are likely to require, and to use, such services.) Most seniors reportedly choose the plan to limit unexpected out-of-pocket expense and because no claim forms are required.

In general, lack of provider interest in Medicare contracting can be attributed to perceptions about the adjusted average per capita cost (AAPCC) used by HCFA as the basis for HMO rates. Tampa's AAPCC rates are notably lower than those in Miami although, according to some plans, Tampa patient care costs through HMOs do not necessarily reflect this. Plan average community rates (ACR), based on costs of non-Medicare enrollees, are also high relative to the Medicare AAPCC, offering little additional margin for senior members. (At one HMO in Tampa it was explained that, in the industry, the general rule concerning Medicare is that "the AAPCC must be four times a plan's average community rate (ACR) in order to survive under risk-based capitation.") Providers also note that neither marketing nor administrative costs are included in Medicare rates and that the program does not reflect true physician charges, averaging "30-40 cents on the dollar" for local plans.

These factors have discouraged provider involvement with Medicare, especially with risk-based contracts. This reticence was summarized by the comments of an executive at one of Tampa's large IPAs, who notes "if our plan experience exceeds cost with employer groups, we can request renegotiation of the rate and obtain an appropriate increase. If this happens with Medicare, we're stuck. Why should we subsidize the government with this sort of risk to the plan?" All plan administrators, in fact, agreed that contracting arrangements required alternative rate approaches to encourage plan enrollment of Medicare beneficiaries.

5.0 MEDICAL PRACTICE PATTERNS

5.1 Background

In the Tampa/St. Petersburg area, changes in utilization of hospital services have been pervasive across hospitals and represent the usual pattern: shifts in services from inpatient to outpatient settings; shorter lengths of stay, and reduced censuses. In addition to PPS and PRO activities, there are features of the health system in this area that contribute to the general use patterns and to hospitals' responses to PPS. In particular, the area is a very competitive place for MDs. Physicians are very concerned with market and income risks. Much of this pressure stems from the invasion of managed care entrepreneurs into the region, but large and increasing stocks of MDs have also sensitized doctors to market forces.

In addition, the highly transient elderly population and the high degree of penetration of storefront ambulatory care centers into the market have created competitive pressures in Tampa and St. Petersburg that are not usually faced by physicians in other metropolitan areas. The area's aftercare markets are different, and basically reflect Medicare coverage policy. Competition for HHA business is intense due to 1) the Medicare benefit; 2) the large elderly population; and 3) the demise of the certificate of need process. Other (non-covered) home and community-based service markets are very underdeveloped, in spite of the large elderly population and state Medicaid program initiatives. The number of nursing home beds and amounts of congregate housing are probably excessive, though that market is clearly bifurcated between private pay and Medicaid.

The physicians in the region are also uncommonly concerned with sources of payment, due in part to the fact that Medicaid has not increased fees since 1972 and in part to the significant role of proprietary health care enterprises in the area. This has caused many physicians to focus practices explicitly on private pay, commercial, and Medicare patients, placing unusually heavy burdens of indigent outpatient care and the corollary inpatient services on several hospitals. As a result of these pressures, use of hospitals by physicians has traditionally been extensive, though that is changing under the pressures of a growing managed-care sector.

Finally, it is important to note that malpractice costs for MDs' coverage have been a very important concern for hospitals and physicians. Chain affiliated and larger (self-insured) hospitals seem to be better able to insulate physicians from insuror-imposed increases in coverage limits, which seems to have altered the terms on which hospitals compete for admitting physicians.

5.2 Hospital Responses to PPS

As in most places in the country, there is no consistency across hospitals in terms of the role of patient management changes in hospitals' strategic response to PPS. In the Tampa area, some hospitals

are basically ignoring physician behavior, except as it relates to PRO oversight. Other hospitals indicate a more central concern over patient care management, though even in these hospitals no significant new controls over physicians' command of hospital resources are reported. It is probable in these cases, that strategic concerns over physicians' decision-making would have existed even in the absence of PPS, due to the growing role of managed care in the area.

Two things are clear about hospitals' strategic response to PPS. First, little is being done actively by hospitals in the area to control physician behavior that is not mandated by the PRO. Second, aspects of cost control other than utilization management (like nurse staffing and salary policies) are definitely occurring, suggesting a "budget control" response to PPS rather than one that might be characterized as "physician control."

Hospitals are attempting, to varying degrees, to control the way physicians use the hospitals' services and facilities. Admissions are more carefully scrutinized though no hospital appears to review the necessity of all admissions. All hospitals report few "social" admissions, as a result of PRO criteria. There is an obvious trend to create a role for an "admitting nurse," distinct from the traditional role for continued stay (LOS) review. Generally, Medicare admissions are reviewed against criteria retrospectively. However in one hospital, all Medicare admissions are reviewed prospectively by a nurse/DRG coordinator on the basis of a phone call from the admitting physician. This strategy is complemented by a more intense physician education program which includes one-on-one discussions with physicians, a DRG newsletter for physicians, and formal lectures and presentations. The hospital has made few pre-admission review denials to MDs (and the PRO has subsequently rejected few as well), but there is a general consensus that lower Medicare admission rates have resulted from the "sentinal" posed by the phone call.

Efforts to control intensity (including LOS) are neither substantial nor innovative in the Tampa hospitals participating in the site visit. Generally, all Medicare cases are reviewed several times per week -- but in no case are all non-Medicare cases getting such scrutiny. In several (but not all) hospitals, the chart notes the DRG and expected LOS. In one hospital, the billing/posting MIS notifies the UR office when LOS targets or a charge threshold is exceeded. In only a minority of hospitals are reports periodically sent to physicians and administrators showing physician profiles and patient performance. In one case, physicians are required to provide written justification when the LOS threshold is exceeded. No hospitals reported any investments in ancillary or special care utilization control, though telemetry products are making it possible to manage patients in less costly units.

Two hospitals have developed special antibiotic policies/services. In part, these activities are aimed at traditional quality assurance but cost control motives are also explicit. Indeed, one hospital notes that it has decided, on more than one occasion, to pay for post-discharge IV antibiotic therapy rather than keep Medicare-patients on the floor

(Medicare pays for drugs only when the patient is hospitalized). In no cases are there reported sanctions against physicians for volume abuses. As with admissions, actions are being taken by hospitals, but little is directed at physicians -- rather, various procedures have been implemented to raise indirectly the cost to doctors of prolonging stays.

Hospitals are actively engaged in activities that would change the mix of admissions. Very little evidence exists, however, that hospital staff or physicians are generally aware of "winning" and "losing" DRGs. There is a general impression that COPD is a "loser" and that cardiac catheterization is a "winner." (Observers note that there may well be 10-12 hospitals within a 50 mile radius offering catheterization services within 5 years.) No detailed product costing studies are reported, nor has anyone suggested that hospitals are pressuring physicians to dump particular DRGs. One hospital employee notes, curiously, that the hospital's bank inquired about the 10 most profitable DRGs in that institution. This request prompted a charge-based study and the results were given to the bank.

As with catheterization, hospitals appear to be attempting to influence patient mix through new service offerings. Obesity and substance abuse clinics, additions of sophisticated diagnostic equipment, and affiliation agreements with satellite walk-in centers with a preferred payor base are mentioned as tactics. Two hospitals are reported to have arrangements with other local hospitals to admit/transfer patients. One such arrangement allows the surgery to be done in one hospital with pre/post-operative care delivered at the other facility. The other arrangement uses the lower-cost partner to deliver post-op and general recuperative care. In this instance, the readmission/transfer policies of the PRO are reportedly limiting what appears to be a cost effective division of labor.

Physician recruiting to achieve a better mix of patients is not a tactic of Tampa area hospitals. Only one hospital still reportedly offers income guarantees to new physicians, though more aggressive behaviors (discounting ancillary services) are used in recruiting established admitting MDs. The most interesting effect of PPS on physician supply concerns older physicians. A number of UR coordinators (in Tampa and elsewhere) note that compliance with criteria and UR process is excellent because the outlier MDs are often elderly and have retired. The suggested hypothesis is that hospital and PRO processes for review and documentation did, at the margin, encourage retirement of admitting physicians earlier than would have otherwise occurred.

5.3 Outcomes

While it is clear that physicians are utilizing Tampa area hospitals differently than they did in the past, the role of PPS incentives in causing the change is not so apparent. Aggressive penetration of managed (rationed) care plans and PRO requirements are very important factors that have been responsible for much of the observed reductions in admissions and average lengths of stay. Physicians are not aggressively monitored or pressured or sanctioned in

most hospitals, nor are they aware of any hospital strategy that may pertain to the optimization of payment or patient mix. In the context of findings from other locations, it does not appear that the more competitive environments for hospital and physician services in greater Tampa have prompted a more aggressive hospital strategy to manage the activities of admitting physicians.

Nevertheless, hospitals are being used differently by physicians than in the past. Social admissions have been largely eliminated and much surgery shifted to outpatient settings. While physicians generally perceive this outcome as appropriate, there remains considerable concern that strict PRO criteria are unnecessarily discouraging admissions for asymptomatic but clinically appropriate episodes of hospital care. There is evidence that persevering physicians are, in fact, able to get admissions authorized through documentation, however. Lengths of stay have been reduced. Again, most physicians reportedly believe this to be appropriate in most cases.

There is concern about threats of reduced quality, generally relating to the availability of suitable home care. One physician notes that he feels a need to specify the home care agency, for fear that incompetent providers will be selected without his interventions. Additional difficulties in the discharge planning process in Tampa area hospitals, which raise concerns about the patient care consequences of shorter stays, are discussed below in Section 6.0. Physicians report high rates of readmission, but do not perceive this as a symptom of inadequate lengths of stay.

The mix of patients across hospitals is also changing. While some specialization in care might be attributed to PPS incentives, in no case is there evidence that sophisticated skimming and dumping by DRG is occurring (other than across the board pursuit of cardiac catheterization services). Skimming and dumping by payor class is an obvious business strategy throughout the area, however. Access to good care for indigent (and Medicaid) patients is perceived as inadequate. This is largely attributed to Medicaid payment policies and malpractice liability and the (defensive) need to target insured populations in the aggressively competitive environment. Nevertheless, respondents argue that the PPS system does not help the growing problem for the poor. One physician suggests that physician services to indigents be allowed as an income tax deduction.

Finally, one physician respondent reports an urgent problem with the correspondence used by Medicare to report coverage and payment determinations. The concern is that the language used to report PRO findings that bear on coverage is not comprehensible to beneficiaries. This is, reportedly, potentially damaging to patient-physician relationships. The respondent offers to redraft the form letter for the PRO.

6.0 THE POST-HOSPITAL HEALTH CARE INDUSTRY

6.1 Overview

Tampa and St. Petersburg have substantially different populations and different health care needs. Post-hospital care providers in Tampa face the "normal" problems of serving a diverse population, whereas in St. Petersburg community-based services are particularly challenged by a large population of very old, very needy people. The Tampa Bay area in general has low hospital occupancy rates and an excess supply of nursing home beds; the health services system is very competitive, with HMOs wielding substantial influence.

The immediate Tampa area contains a proportion of elderly that is above the national average: around 15 percent are over 65. This proportion is relatively small, however, compared to St. Petersburg, which has an extremely large elderly population: nearly one-third are over 65, and 28 percent are over 75, an age where service needs increase. Many observers say that Florida is behind other parts of the nation in the provision of community-based services, having relied traditionally on nursing homes and board-and-care homes. There is only a limited state-funded community care system through Medicaid.

In areas with heavy concentrations of elderly, moderate income people, such as south St. Petersburg, hospitals struggle to accept, care for, and locate post-discharge services for many very ill, disabled, low income elderly. These facilities are in a bind of caring for very needy patients, while discharging them before they pose a serious financial burden on the hospitals. Nursing homes and Adult Congregate Living Facilities (ACLFs) are often the only alternative if community services are unavailable.

In this site, as in others across the country, discharge planning activities vary widely across hospitals. One hospital, with virtually no indigent patients, devotes very little effort to this activity. In hospitals with substantial numbers of difficult-to-discharge patients, resources remain limited and the amount of effort depends largely on the individual staffing the function.

The Health Maintenance Organization (HMO) situation in Florida is complex, competitive, and controversial. Discussions of HMO behavior in terms of misleading and underserving Medicare beneficiaries are widespread; HMOs probably affect overall hospital admissions and lengths of stay, as well as provision of post-hospital care. The HMO receiving the most criticism is an aggressively marketed HMO with a large Medicare enrollment. Comments are the same from all fronts: hospitals aren't paid; physicians aren't paid; patients receive little or no home care, few specialty consultations, and little ongoing care, so that by the time they are hospitalized it is often for an emergency.

6.2 Hospital Admissions and Discharges

There is general agreement that Medicare lengths of stay are shorter, and that people are now being discharged with greater care needs than in the past. Even though change has been fairly rapid in the past

few years, some hospital staff seem not to have noticed the increase in referrals to home health care. One hospital discharge planner says there has been no increase in referrals to home health agencies, but a look at this hospital's statistics reveals a doubling of referrals per month from 1984 to 1986. Home health agencies report increased referrals in general.

More patients are being sent home with heavier care needs, though it is not clear how much the actual provision of "high tech" care in the home has increased. Need for daily care, complex care, and basic support services has grown, and home health agencies perceive that they are providing more high tech care.

6.3 Hospital Discharge Planning

All discharge planners interviewed say they believe their hospitals now take discharge planning more seriously as a result of PPS; they see its money-saving possibilities. However, discharge planning staff, as well as some utilization reviewers and other staff, indicate that this interest is not carried out in actions. The function appears to be sparingly staffed in most of the hospitals, with little indication of plans to add resources. There is always a trade-off between a hospital's desire to improve the efficiency of the discharge process and the need to pare down administrative and other staff for the sake of economy. Discharge planning appears to be an activity that is caught between these conflicting needs.

A second problem in the discharge planning process appears to be the role of the physician. More hospitals are permitting discharge planning staff to review patient records and talk to patients without waiting for physician referrals. Nevertheless, planning activities often do await the physician, for reasons that are unclear. Perhaps some patients do not fall into obvious risk categories. Last minute physician referrals to discharge planning thus continue to be a problem; pre-holiday and pre-weekend discharges create special problems in this area. Physicians are widely perceived to know little about community services, and thus do not often prescribe them. Physicians reportedly see discharge planning as limited to the need for a nursing home versus going home without care needs; the living situation and its implications for patients with needs for care do not always figure in their decisions.

6.3.1 Organization

Discharge planning activities in the Tampa area hospitals participating in the site visit, are usually staffed by social workers, although nurses have the responsibility in two instances. The locus of the function is usually the Social Work Department.

The scope and authority of discharge planning staff varies across hospitals. While physicians continue to play a major role, most discharge planners have the authority to review patient records to determine the need for discharge planning. Some pursue their roles

aggressively through automatic computer screens, high risk screens, and direct approaches to patients and physicians. Even though planners may perform needs assessments, in some hospitals a physician referral must be obtained before the patient is seen.

Some hospital discharge planning staffs take a relatively passive role. They identify patients using their high risk screens, but simply place a sticker on the patient's chart (for the doctor to see) asking, "Does this patient need discharge planning?"

6.3.2 Risk Screens

All hospitals have screens to determine who should receive early attention to post-hospital needs. All accredited hospitals have written criteria, a requirement of the JCAH. The criteria do not always seem to be institutionalized. However, virtually all discharge planners look for certain things:

- Medicaid status;
- Referral from a nursing home or ACLF
- Over a certain age (75-80)
- No informal supports (relatives, etc.)
- Certain conditions (stroke, cancer, hip fractures).

6.3.3 Functions

Traditionally discharge planning has focused primarily on financial problems and obtaining institutional placements. These activities still play a major role; in fact, certain changes in Florida programs have increased this burden. Discharge planning/social work is responsible for assisting patients with applications for Medicaid and other public welfare programs. Florida has recently implemented a medically needy program, increasing the work of discharge planning staff. The primary burden has been in learning the guidelines for eligibility and application in a new program, as well as increasing the numbers of patients for whom application procedures are needed.

Florida has also instituted a pre-admission screening program for nursing home placements, called the Comprehensive Assessment, Review and Evaluation System (CARES). The Geriatric Assessment Testing System (GATES) is conducted for each patient prior to hospital discharge by state Medicaid program staff. This has resulted in a somewhat cumbersome discharge and placement process, although there are few major complaints. The screening program is designed to divert patients, if possible, from institutional placements to community-based services. A major practical impediment is the shortage of public community services and personal support systems for many elderly people.

The final area of discharge planning responsibility is community services, primarily referrals to home health agencies. Hospitals in this area do not appear to rely heavily on nurses from home health agencies to come into the hospitals, review records, and set up homecare plans, as in some other areas of the country. Hospitals do their own referrals to

home care; some have formal or informal arrangements with at least one home health agency, but quite a few use a rotation system of referrals. In other words, they maintain a list of certified HHAs in the area, and call each one in turn when they have a referral.

6.3.4 Problems

The major complaint voiced by discharge planners was the lack of community services for just-released patients; particular shortages are meal programs, funds for personal care services, and informal care. One hospital social work director has had long community involvement, and has helped establish community support groups and services. The Area Agency on Aging staff report that 20 percent of the elderly need such services, but that only 12 percent of those actually receive them. There are long waiting lists for services such as Meals on Wheels.

Another problem is obtaining skilled nursing care beds for very sick patients, in spite of the high nursing home bed supply and low occupancy rates. Lack of payment sources for nursing home care also create placement problems. Funds for short-term personal care and support services are unavailable, and many elderly have no resources to pay for them. Yet a major problem is in the immediate post-hospital period, particularly for patients who do not need Medicare skilled level services. Spouses are either absent or unable to provide care themselves in many cases.

6.4 Home Health Agencies

The Tampa Bay area seems to be characterized by a high level of competition in home health care. Several of the HHAs interviewed have had to face decreasing caseloads as the result of two factors. First, some HMOs in the area have been successful in recruiting Medicare enrollees. HMOs frequently contract with existing HHAs to care for their patients, and they do that here. However, at least one HMO contracts with HHAs but reportedly provides very little home health care. Thus this HMO effectively removes the Medicare enrollees from the home health market.

The second reason for decreased caseloads has been the growth in the number of HHAs since Florida relaxed its Certificate of Need requirements, allowing new providers to enter the market. Hospitals have created their own HHAs, usually through joint ventures.

These trends have apparently offset the potential increases in caseload resulting from earlier hospital discharges; the caseload simply shifts among providers. Total caseload is, in fact, increasing, but at a slower pace than the growth in providers.

6.4.1 Changes

The home health agencies in the area have had to adapt both to changing numbers and to changing casemix. Declining caseloads have forced some HHAs to reduce staff in order to economize. This has meant

letting go of staff that in many cases have been at the agency a long time and have built up a body of home care knowledge. However, other HHAs have said there is a nurse shortage forcing them to use temporary staffing. Still other agencies report using temporary staffing to accommodate fluctuations in caseload.

Agencies perceive that they are serving more complex, "high tech" patients (IVs, parenteral and enteral nutrition, etc.). In addition, HHAs see patients sooner following surgery, and provide more sterile dressing care. A problem cited as one reason for increased home care needs is that there is now less time in the hospital to instruct patients in self care.

6.4.2 Problems

Crisis planning is required for some patients when they are discharged without any prior notice from the physician. The hospital discharge planner and the HHA must respond rapidly to service needs in these instances.

HHAs feel that they have little control over the nature or size of their caseloads. They are not in the practice of turning away patients, so they see their caseload fluctuating at the whim of hospitals and physicians, who dictate when a patient is to be discharged, hence the amount and type of care needed.

These fluctuations in caseload and types can create problems in maintaining a capable staff. One agency said it takes six months to train a good home health nurse. Inability to keep continuity in staffing results in having to use temporary or new, untrained personnel. Quality may be compromised as a result.

6.4.3 Administrative Problems

Fiscal Intermediary (FI) problems are seen by the home health agencies as major disruptions. Many HHAs have lost their waiver of liability, due in part to the Fiscal Intermediary's change in the method of calculating the claims denial rate. Some HHA administrators believe that the FI is also being squeezed by HCFA through its productivity requirements. The FIs are judged on how much money they "save" in claims denials per administrative dollar earned. Since they no longer review large hospital claims with a high rate of return, they must deny more claims of other types in order to produce these savings.

Stringency of medical review is also seen as a problem, particularly since HCFA imposed the new plan of treatment forms (485 and 486) on the HHAs. Some providers feel that these forms have generated increased denials, in part because HHAs were confused about how to complete them and received little instruction by either the FI or HCFA.

Inconsistencies of interpretation are also said by some to be a problem, although other agencies say they have few problems with the FI. A particular area of inconsistency and confusion is the definition of "intermittent" care. Aide visits are sometimes denied if there is another person living in the household, regardless of whether they are

able to provide the care. The definition of daily care also appears to present problems; daily care is approved only if there is rehabilitation potential and if there is a predictable end to the need for daily care.

6.5 Nursing Homes

Most nursing home administrators visited during the study report that Medicare plays virtually no role for them. None had Medicare patients at the time of the visit. One reports that it usually has only two or three, although it has a substantial number of certified beds. A number of nursing home administrators were contacted by phone but not visited; most of these said that although they have Medicare-certified beds, they have not admitted any Medicare patients in a long time. This situation is consistent with other locations across the country, and appears to be the result of a constant tightening of definitions of the kinds of patients who are eligible for Medicare coverage in a skilled nursing facility.

There is a perception among nursing home directors that the applied definition of skilled care has changed over the years; the amount and frequency of service needed must now be greater and rehabilitation potential must exist. According to nursing home administrators, the FI now requires that a patient be expected to recover complete, not just partial, functioning. The FI often decides who can be expected to achieve full rehabilitation. One example of a case denied was a woman in her 90s with a colostomy, who needed teaching and some rehabilitation, and who was also blind. The FI denied coverage on the grounds of her age and her blindness, saying that the woman could not achieve rehabilitation. She entered the nursing home anyway, and was restored to ambulatory and self care status. One nursing home administrator says that the FI is now denying claims for some patients with hip fractures, whereas in the past these were considered sure cases for Medicare coverage in the facilities.

Hospitals are discharging patients sooner, so nursing homes are admitting patients who are sicker and who are at earlier stages in their recovery process. In general those interviewed do not think this is bad; patients are believed to have gotten as much as they can get from the hospital stay.

The level of illness of patients in nursing homes in general is reported to be higher now, with more tube feedings, hyperalimentation, catheters, and decubitus ulcers. These patients, however, do not qualify for Medicare, presumably because they are considered "chronic" rather than rehabilitative. These problems have required higher skill levels of staff, and more training for them. Training for IVs is particularly needed. Nursing homes, even though they do not have high occupancy rates, still try to screen patients prior to admission in order to maintain some stability of casemix and to assure that their staff is capable of providing the necessary care. They also try to screen out patients for whom there is no payment available.

7.0 PROGRAM OPERATIONS

7.1 Peer Review Organization

7.1.1 HCFA Contracting

The Professional Foundation for Health Care (PFHC) is the Florida PRO. It has had no trouble operating under the scope of work in its new contract with HCFA, which began in August, 1986. As part of this contract, PFHC is required to participate in a study of hospital care with the Rand Corporation that compares the two years prior to PPS to two years after PPS. Six diseases are being tracked in 60 Florida hospitals. PFHC is also participating in a pilot study that examines patients discharged from an acute care setting and then sent home to receive home health care, to determine if the discharges were appropriate.

Faced with recent budget cuts, PFHC has limited its activities to those mandated by HCFA. They have also cut down on travel costs; hospitals now send their representatives to PFHC for meetings. There also has been a general freeze on hiring.

7.1.2 The Review Process

PFHC's review staff is 70 percent, RNs; 15 percent, LPNs; and 15 percent, medical records reviewers. In addition, PFHC has about 260 active review physicians. All review is done on-site and each review coordinator is responsible for two to four hospitals. Cases selected for review include a 3 percent random sample for HCFA's generic quality screens, 100 percent of transfers and readmissions, 50 percent of all length-of-stay and cost outliers, and 100 percent of all claims for those hospitals selected for intense review because of high denial rates. Eighty two of the 269 hospitals in Florida are currently given intense review. Large hospitals are placed on this review list when five percent of their claims have been denied in one quarter. Smaller hospitals may be placed on this list when six of their claims for one quarter have been denied.

Reviewers receive computer printouts of the claims selected for review, and they must give the hospital seven days notice before arriving to review those claims. Once the review is complete at the hospital, the reviewer holds an exit interview with the hospital contact. During the exit interview, the status of each claim is discussed, and either the claim is referred to a physician, more information is requested, or the case is resolved. Reviewers contact physicians in the specialty relevant to that claim and try to arrange the review on site.

Nurse reviewers can examine only the records to see if they meet the intensity of service and discharge criteria. Physicians are not limited to this source of information. If the physician reviewer decides to deny the claim, the attending physician is called and given seven days to submit additional information. Once the determination is made, letters are sent by PFHC to the hospital, physician, and patient. Denials issued on the basis of quality must be the decision of the quality assurance committee.

After a claim is denied, it can still be reconsidered. In principle, reconsiderations should be requested only if there is new information relevant to the claim. Some hospitals will request a reconsideration of every claim that is denied. PFHC receives requests for over 150 reconsiderations a day. PFHC has a panel of physicians on their staff who are employed solely to review reconsiderations. For about 20 percent of the reconsiderations, the denials are reversed.

7.1.3 Denials

Unnecessary or planned readmissions generate the largest number of denials. Many of the hospitals are on the list for intensive review because of readmissions. Hospitals are beginning to do more planning with surgery schedules so that patients are not released and then readmitted later for a surgical procedure. If a hospital has a real scheduling problem then patients can be given "leaves of absence" from hospital stays so that the two stays would be considered one admission and reimbursed under a single DRG payment rate. Readmissions will generate a denial if reviewers find that the quality of care in the first admission was poor enough to require a second admission. In this situation, the first admission would be denied on the basis of quality. PFHC now looks at all readmissions within 15 days.

PFHC feels that, although denials are increasing, hospitals are trying to comply with HCFA's guidelines. Physicians, however, are reported to be less willing to comply. PFHC has held physician workshops but believes ultimately it is the responsibility of the hospitals to educate physicians. PFHC educates its providers through workshops, meetings, and information bulletins.

When a hospital has so many denials that sanctioning is considered, PFHC attempts to remedy the situation before resorting to sanctions. Meetings are set up with problem hospitals to try to better educate them. Before proceeding with a sanction, all claims in that time period are rereviewed by physician specialists. Once the final decision has been made to sanction, the hospital is notified in writing. So far, three hospitals have been sanctioned by this PRO. However, PFHC predicts that in the next two years there will be more sanctions.

7.1.4 Changes Since PPS

According to PFHC respondents, hospitals are discharging more patients needing additional services than before PPS. Many SNFs and HHAs in Florida have apparently been unable to provide this higher level of care. For example, PFHC has discovered through discussions with SNFs and HHAs, that members of their nursing staff do not know how to start an intravenous (I.V.) tube. These aftercare providers are trying to obtain more skilled staff. Florida has many of the necessary aftercare services in the community. However, PFHC feels that some patients are not getting care they need because particular services are not covered by Medicare, and the patient cannot afford to pay for the care out of pocket.

PFHC does not encounter many cases of unnecessary transfers or "dumping." However, in the case study site area, there is a problem with a large teaching facility transferring patients to the county hospital. The county hospital has agreed to admit some Medicare patients, but has told them that Medicare will not pay for their care.

7.1.5 Relations with Providers

Providers have accused PFHC of being too strict and "by the book." For example, attending physicians are required to sign and date each claim. There have been over $250,000 worth of denials due to attestation problems. PFHC tries to be empathetic to the hospitals; however, they feel that they have no more control over the situation than the hospital does. Providers are given the opportunity to suggest changes in the scope of work during contract negotiations with the PRO. However, the changes made in response to hospitals' suggestions have only been minor ones.

Each hospital's DRG coordinator or director of medical records is typically the contact person with the PRO. If there are any problems between the PFHC's reviewer and the contact person, then the area manager goes on site and arbitrates between the two. PFHC reports that there are a few problems. Occasionally the review coordinator's previous employment at the hospital creates some conflict. However, it is more common for the PRO review coordinators to be hired away by the hospitals, which can afford to pay them higher salaries. Some of the hospitals are unhappy about the high turnover rate for PRO review coordinators. Hospitals perceive a large variability in the competence of the reviewers and this influences their relations with the PRO.

7.2 Fiscal Intermediary

Blue Cross and Blue Shield (BCBS) of Florida is the Medicare Fiscal Intermediary for all inpatient, SNF, OPD and provider-based HHA claims. The majority of HHAs are freestanding and these claims are processed by Aetna. About 70 percent of providers send BCBS their claims electronically, and they immediately enter the processing system. Hard copy claims begin the process at the control services area. Here they are sorted into types of claims, given a document control number, batched into groups of 50 or less, and forwarded to the claims process area.

At the claims process area, each data entry operator is given a batch of claims to enter into the system. The operator enters the type of batch and the number of claims in the batch and the appropriate field is displayed on the screen. On-line consistency edits make it nearly impossible for an operator to skip a claim or enter an incorrect number. If consistency errors are found at this stage, the system will automatically send a letter out to the provider. About 2 percent of the hard copy claims are returned to the providers for consistency errors found during data entry. The clean claims are then stored in the database and join the electronically transmitted claims in the system.

Every night, BCBS runs the claims through a series of editing modules. The first two modules do consistency edits and check for duplicate claims. For example, any claims with duplicate dates of service, including beneficiaries with outpatient claims and inpatient claims on the same date, are automatically rejected. Claims that pass these edits flow into the eligibility module, to establish entitlement dates. Inpatient claims then enter the utilization module. Here the MCE grouper program determines the DRG from the diagnostic codes and ensures that the DRG and the diagnostic codes on the claim are valid.

All the claims then flow into the medical policy module (MPM). In this module are the PRO's screens for types of claims that require prepayment approval. Any claims that fail these screens get sent directly to the PRO. The MPM also contains the HCFA quality screens and BCBS's review screens for the SNF, HHA, and OPD claims. Claims that pass these screens then flow into the payment module. The payment module determines the reimbursement amount for the claim, incorporating any deductibles or other adjustments. The claims then enter the control module where data is stored and remittances are produced for providers.

In the morning, the suspended, or "kicked out" claims are reviewed and the inpatient claims are sent to the PRO. The PRO receives the claims on a daily basis. The remittance cycle of the process is run three nights a week. Claims that have been received in hard copy form are paid not earlier than 21 days (no sooner than 28 days as of January 1, 1987). Claims received electronically are paid no earlier than seven days after being received.

About 20-22 percent of the processed claims are suspended. This includes those claims suspended for medical review. The most common technical errors found are invalid HIC numbers and duplicate claims.

7.2.1 Utilization Review and Medical Review

The medical policy module screens claims across almost 10,000 parameters. Before BCBS created this module, only a five percent sample of the claims were screened. When the claims are suspended for medical review, BCBS notifies the providers to send in the records. BCBS has a staff of seven nurse reviewers who review the records. If still unresolved, the case is referred to a member of BCBS's physician staff. This individual reviews the claim and renders a final decision. Only about five or 10 claims a year go to the physicians for review. When a decision on a claim is appealed the record is sent to a different nurse reviewer. The number of appeals have been increasing since BCBS has intensified their review process to try and meet the five (dollars in payments) to one (dollars in administrative costs) savings ratio. Their average ratio is eight to one.

7.2.2 HHA Definitions

BCBS defines care as intermittent for HHA patients if a skilled nurse goes into the home at least once every sixty days. The definition for daily care is determined on a case by case basis. If it is medically

necessary that the patient receive care every day, the claim may be allowed. However, BCBS pays close attention to how well the nurses are teaching the patients to care for themselves so they can be weaned off daily care.

BCBS has had some problems with the definition of homebound. If a patient has a physical condition so that it is a hardship to leave the home to see a physician then he or she is homebound. BCBS feels that many times they know the patient isn't really homebound but according to the documentation they qualify for it. Nevertheless, many of the HHA appeals for claims denied are on cases used on the homebound requirement. As mentioned earlier, BCBS monitors closely the skilled care that is given to patients. Once it seems reasonable to believe that the skills have been taught to the patient, BCBS feels it is no longer necessary for him or her to receive home health care.

7.2.3 Denials

All of the home health definitions are problematic for the agencies. Providers who have repeated denials because they do not meet definitions can visit BCBS and get advice on the proper documentation necessary. BCBS only processes claims for hospital-based HHAs which have less denials than freestanding HHAs. When the 485-488 forms were first implemented, there were many denials. The forms do not allow room for more than minimumal documentation. Most of the HHA denials have been for technical reasons; incomplete documentation or the plan of treatment described not considered necessary and reasonable. BCBS held a workship to teach providers how to use this form. Lately, providers have become more accustomed to using the form and denials have decreased.

For skilled nursing facilities (SNFs), physical therapy is a major source of denials for not being necessary and reasonable. Outpatient claims generate the most denials at BCBS. For example, there are many problems with cardiac rehab patients. Denials are made because many of the services for these patients such as respiratory therapy are not covered by Medicare.

BCBS feels that HCFA's regulations are broad and leave a great deal of room for misinterpretation. In addition, BCBS sees problems for providers with high turnover rates in personnel. Inexperience can cause denials, until the new employees learn the proper documentation techniques and eligibility requirements for reimbursement of treatments and services under Medicare.

7.2.4 Earlier Discharges

According to BCBS, hospitals are not keeping patients as long as they did before PPS. Both HHAs and SNFs are seeing patients who haven't progressed as far through the recovery process and need more services than pre-PPS. Aftercare providers can no longer assume that patients are discharged at the "correct time" and must try to provide the missing services. In Florida, as in many states, more high-tech care is being done outside the inpatient setting. Patients can now be given I.V.

antibiotics in the home. Two hospitals in the Tampa area mention this problem. Their solution is to pay for the antibiotics for the patient themselves. This is less expensive for the hospitals than keeping the patient in the hospital for the full period of treatment.

7.2.5 Relations with Providers

BCBS makes a strong effort to educate their providers before changes in HCFA guidelines are implemented. Unfortunately, they feel they often do not get HCFA mandates in time to educate properly. BCBS sends providers notification of any changes in payment rates and calculates the provider's blended rate. Most of the problems providers had in moving from the old to the new payment system have reportedly been solved.

7.2.6 External Relations

As of January 1, 1987, fiscal intermediaries reportedly have to delay their payments until almost a month after receiving the claims. BCBS is concerned about this change, and feels it will be hard to implement. HCFA's requirement of a 5 to 1 savings ratio is the item on the CPEP score that is very hard for most FIs to meet. This FI complains, as others have, that without the opportunity to review inpatient claims, it is nearly impossible to meet this goal. In general, Florida BCBS's ability to meet HCFA standards has been exemplary; in 1985, BCBS reportedly tied with the Mississippi FI for the best CPEP score.

BCBS communicates with HCFA only through the regional office, so there is no problem with conflicting directives. There is a regional office representative onsite at BCBS to provide clarification of guidelines. There have been some problems interpreting the HHA definitions. The regional office will seldom be specific enough to satisfy BCBS. It is often necessary to send appeals of definitions to an administrative law judge.

When faced with budget cuts, BCBS looks at what can be automated, tries to streamline processes, and shift resources to be more efficient. Because of the high level of automation, this FI already has only half the staff of other FIs for states this size. They have tried not to cut down on provider education because they feel that doing so would only create problems in the long run.

CMS LIBRARY
3 8095 00013569 5